



ENROLLMENT FORM FOR NEW MEMBERS

State Form 37680 (R12 / 2-08)
Approved by the State Board of Accounts, 2008

Indiana State Teachers' Retirement Fund
150 West Market St., Suite 300
Indianapolis, IN 46204-2809
Telephone: (317) 232-3860 / (888) 286-3544
Home page: <http://www.in.gov/trf>

PRIVACY NOTICE

Your Social Security number is requested by this agency in accordance with the requirements of IRS Code 3405. Disclosure is mandatory; this form will not be processed without this information.

TRF Number (Office Use Only)

INSTRUCTIONS:

This form is for new members of the Indiana State Teachers' Retirement Fund. **Pre-existing members wanting to make changes to their account should use the "Request for Member Data Change" form State Form 43567 that is available from our offices.** The employer must sign to certify that the member meets eligibility requirements.

Please forward the completed form to the retirement system within five (5) days of the teacher's date of employment. You must complete all items on this form, using "N/A" where not applicable. If an employee is already a member, we do NOT need a new membership record.

PLEASE USE BLACK INK ONLY

MEMBER INFORMATION

Social Security Number	Marital Status Married Single	Gender Male Female	Date of Birth (mm/dd/yyyy)
First Name	MI	Last Name	
Address		Home Phone Number	
		Other Phone Number	
		Email Address	
City	State	Zip Code	

You are required to submit a copy of your Social Security Card and Birth Certificate from your Public Health Department. If you do not submit a copy of your Social Security Card and Birth Certificate with this form, you must forward one to the Teachers' Retirement Fund as soon as possible.

PREVIOUS MEMBERSHIP INFORMATION (To be completed by member)

Have you ever served on active duty in the Armed Forces of the United States?	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Have you previously been employed in a position covered by the Indiana Public Employees Retirement Fund?	<input type="checkbox"/> YES	<input type="checkbox"/> NO
If yes, are you receiving benefits from the Indiana Public Employees Retirement Fund?	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Have you previously been employed in a position covered by the Indiana State Teachers' Retirement Fund?	<input type="checkbox"/> YES	<input type="checkbox"/> NO
If yes, are you receiving benefits from the Indiana State Teachers' Retirement Fund?	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Have you ever served in an out-of-state teaching position?	<input type="checkbox"/> YES	<input type="checkbox"/> NO

BENEFICIARY INFORMATION

Primary Secondary	Social Security / Tax I.D. Number	Beneficiary	Date of Birth	Relationship
Primary Secondary	Social Security / Tax I.D. Number	Beneficiary	Date of Birth	Relationship
Primary Secondary	Social Security / Tax I.D. Number	Beneficiary	Date of Birth	Relationship
Primary Secondary	Social Security / Tax I.D. Number	Beneficiary	Date of Birth	Relationship

In accordance with the provisions of Ind. Code § 21-6.1-4-8, I designate the above as my primary beneficiary. If the primary beneficiary herein nominated shall survive me, he or she shall receive all funds due to a beneficiary from my participation in the Teachers' Retirement Fund. If the primary beneficiary shall not survive me, then the secondary beneficiary shall receive such funds; if neither shall survive me, then the beneficiary shall be my estate. I understand that I have the right to designate "NONE" as secondary beneficiary or both primary and secondary beneficiary. If no designation is made, any death settlement due would be payable to my estate. I reserve the right to change the primary or secondary beneficiary at any time prior to retirement by filing a "Data Change Form" with the Board of Trustees of the Indiana State Teachers' Retirement Fund.

Signature of Member	Date of Signature (mm/dd/yyyy)
---------------------	--------------------------------

CURRENT EMPLOYMENT INFORMATION (To be completed by employer)

Employer Unit Number	Name of Employer	Date Employed (mm/dd/yyyy)
----------------------	------------------	----------------------------

EMPLOYER CERTIFICATION

Pursuant to Title 515 IAC et seq., by signing below, you are verifying that the above individual is qualified to serve as a teacher.

Authorized Signature	Title	Date of Signature (mm/dd/yyyy)
----------------------	-------	--------------------------------